VERIFICATION OF PRESENT SUPERVISING PHYSICIAN

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO YOUR PRESENT SUPERVISING PHYSICIAN.

DEAR PRESENT SUPERVISING PHYSICIAN:

In applying for a license to practice as a Physician Assistant in South Dakota, the Medical Board requires this form to be completed by my present supervising physician. This is your authority to release any information in your files, favorable or otherwise, direct to:

South Dakota State Board of
Medical & Osteopathic Examiners
125 S. Main Ave.
Sioux Falls, SD 57104

_____
(Signature)

Name: _____

Address: _____

_____

DO NOT DETACH

Name of Present Supervising Physician: _____

Name of Employee: _____

Was employee's employment terminated? _____ (Yes/No)

If YES, Why? _____

_____

Derogatory Information, if any _____

_____

Comments, if any _____

_____

Signed: _____
Supervising Physician

Title: _____

Date: _____